



Texas Department of Insurance

Division of Workers' Comp

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS ORTHOPEDIC HOSPITAL
3701 KIRBY DRIVE SUITE 1288
HOUSTON TX 77098

Respondent Name

DEEP EAST TEXAS SELF INSURANCE

Carrier's Austin Representative Box

Box Number 42

MFDR Tracking Number

M4-09-1113-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per Rule § 134.401(c)(6)(A)(i)(iii), once the bill has reached the minimum stop-loss threshold of \$40K, the entire admission will be paid using the stop-loss reimbursement factor ('SLRF') of 75%." "I am faxing this to you because our office has been closed as a result of Hurricane Ike. We have been without power and had several windows blown out of our office. The broken glass and water damage has created a dangerous situation that precluded us from being able to enter our office and access our files."

Amount in Dispute: \$46,858.95

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider asserts that the Stop-Loss Method should be applied for reimbursement of the disputed charges. However, the Stop-Loss provision of DWC Rule 134.401(c)(6) specifically states that 'the diagnosis codes specified in (c)(5) are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate.'" "In addition, please note that the DWC060 filed by the provider indicates that the total bill was \$76,069.49 when in fact, the total billed charges was \$53,407.34. The DWC060 also indicates that the total amount paid by the carrier is \$10,193.17 when in fact, the total amount paid was \$28,581.97. We also note that the amounts the provider is documenting to be in dispute is incorrect on the DWC060." "Furthermore, the provider/requestor failed to timely file this request for medical dispute resolution since the services were from September 18, 2007 to September 21, 2007 and the postmark date was over one year later on September 29, 2008."

Response Submitted by: Deep East Texas SIF, 2615 Calder, Suite 220, Beaumont, TX 77702

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
September 18, 2007 through September 21, 2007	Inpatient Services	\$46,858.95	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401(c)(5)(A), effective August 1, 1997, 22 TexReg 6264, requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate.
3. 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 TexReg 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. This request for medical fee dispute resolution was received by the Division on September 29, 2008.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - W4-No additional reimbursement allowed after review of appeal/reconsideration.
 - W10-No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.

Findings

1. The respondent states in the position summary that "Furthermore, the provider/requestor failed to timely file this request for medical dispute resolution since the services were from September 18, 2007 to September 21, 2007 and the postmark date was over one year later on September 29, 2008."

The requestor states in the position summary that "I am faxing this to you because our office has been closed as a result of Hurricane Ike. We have been without power and had several windows blown out of our office. The broken glass and water damage has created a dangerous situation that precluded us from being able to enter our office and access our files."

This dispute involves dates of service September 18, 2007 through September 21, 2007. The dispute was filed to TDI-DWC MFDR on September 29, 2008. The respondent has raised the issue of timeliness for filing a medical fee dispute; TDI-DWC addresses the issue as follows.

- The healthcare was provided in Houston, Texas which is located in Harris County.
- On September 8, 2008, Governor Rick Perry issued a proclamation declaring that Hurricane Ike poses a threat of imminent disaster along the Texas Coast and in numerous counties including Harris County. The declaration states in pertinent part: "THEREFORE, in accordance with the authority vested in me by Section 418.014 of the Texas Government Code, I do hereby declare a state of disaster based on the existence of such threat and direct that all necessary measures both public and private as authorized under Section 418.017 of the code be implemented to meet that threat. As provided in Section 418.016, all rules and regulations that may inhibit or prevent prompt response to this threat are suspended for the duration of the state of disaster."
- Governor Perry issued subsequent proclamations extending the state of disaster for the named counties due to the substantial destruction in South and East Texas. To date, the Hurricane Ike Disaster Proclamations cover a period from September 7, 2008 through March 6, 2009 for Harris County.
- The Texas Department of Insurance issued Commissioner's Bulletins #B-0064-08, #B-0066-08, #B-0070-08 and #B-0012-09 as a result of the Governor's Proclamation. The bulletins states in part "Under these disaster circumstances for system participant residents of...Harris (and other named)...counties and regardless of where those residents may be currently located, the Texas workers' compensation deadlines for the following procedures are tolled through the duration of the Governor's disaster proclamation: workers' compensation claim notification and filing deadlines, medical billing deadlines, and

medical and income benefit dispute deadlines.”

- Division rule at 28 TAC §133.307(c)(1)(A), states in pertinent part “A request for medical fee dispute resolution...shall be filed no later than one year after the date(s) of service in dispute.”
- In this dispute, Division rule at 28 TAC §133.307(c)(1)(A), is computed by **counting** each day up to and including September 6, 2009, then by **NOT counting** each day from September 7, 2008 through March 6, 2009, and finally by counting of days from March 7, 2009 and on. In other words, the total days would be computed by adding only the days counted before, and the days counted after the tolled period, not to include any of the days in the tolled period.

MFDR’s obligation under the Governor’s Proclamations and the Commission’s Bulletins is to accept dates of service September 18, 2007 through September 21, 2007 as timely because the one-year dispute filing deadline, in this case, is tolled.

2. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when “Trauma (ICD-9 codes 800.0-959.50)” diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 823.82. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
3. The requestor asks for reimbursement under the stop loss provision of the Division’s *Acute Care Inpatient Hospital Fee Guideline* found in Division rule at 28 TAC §134.401(c)(6). The requestor asserts in the position statement that “Per Rule § 134.401(c)(6)(A)(i)(iii), once the bill has reached the minimum stop-loss threshold of \$40K, the entire admission will be paid using the stop-loss reimbursement factor (‘SLRF’) of 75%.” Division rule at 28 TAC §134.401(c)(6), effective August 1, 1997, 22 TexReg 6264, states, in part, that “The diagnosis codes specified in paragraph (5) of this subsection are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate.” As stated above, the Division has found that the primary diagnosis is a code specified in Division rule at 28 TAC §134.401(c)(5); therefore, the disputed services are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 TAC §134.1.
4. 28 Texas Administrative Code §133.307(c)(2)(C), effective May 25, 2008, 33 TexReg 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include “the form DWC-60 table listing the specific disputed health care and charges in the form and manner prescribed by the Division.” The respondent states in their position summary that “In addition, please note that the DWC060 filed by the provider indicates that the total bill was \$76,069.49 when in fact, the total billed charges was \$53,407.34. The DWC060 also indicates that the total amount paid by the carrier is \$10,193.17 when in fact, the total amount paid was \$28,581.97. We also note that the amounts the provider is documenting to be in dispute is incorrect on the DWC060.” Review of the submitted medical bill indicates that the total charges for this hospital admission were \$53,407.36, not the amount listed on the *Table of Disputed Services*. Based upon the submitted EOBs indicates that the insurance carrier paid \$28,581.97 not the amount listed on the *Table of Disputed Services*. Review of the submitted documentation finds that the requestor has not completed the form DWC-60 table listing the specific disputed health care and charges in the form and manner prescribed by the Division. The requestor has therefore failed to complete the required sections of the request in the form and manner prescribed under §133.307(c)(2)(C).
5. 28 Texas Administrative Code §133.307(c)(2)(E), effective May 25, 2008, 33 TexReg 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include “a copy of all applicable medical records specific to the dates of service in dispute.” Review of the submitted documentation finds that the requestor has not provided copies of all medical records pertinent to the services in dispute. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(E).
6. 28 Texas Administrative Code §133.307(c)(2)(F)(iv), effective May 25, 2008, 33 TexReg 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include “a position statement of the disputed issue(s) that shall include”... “how the submitted documentation supports the requestor position for each disputed fee issue.” Review of the submitted documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iv).
7. 28 Texas Administrative Code §133.307(c)(2)(G), effective May 25, 2008, 33 TexReg 3954, applicable to requests filed on or after May 25, 2008, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable.” Review of the submitted documentation finds that:

- The requestor's position statement asserts that " Per Rule § 134.401(c)(6)(A)(i)(iii), once the bill has reached the minimum stop-loss threshold of \$40K, the entire admission will be paid using the stop-loss reimbursement factor ('SLRF') of 75%."
- The requestor seeks reimbursement for this admission based upon the stop-loss reimbursement methodology which is not applicable per Division rule at 28 TAC §134.401(c)(6).
- The requestor does not discuss or explain how additional payment of \$46,858.95 would result in a fair and reasonable reimbursement.
- Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	9/27/2011 _____ Date
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_____ Signature	_____ Medical Fee Dispute Resolution Manager	9/27/2011 _____ Date
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YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.